

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 1 / 4 3

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John Adamson</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/6/82</i> | |
| 3. SEX <i>Male</i> | | 2b. HOUR <i>10:55 AM</i> | |
| 4. RACE <i>Black</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>49</i> | |
| 5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 14, 1932</i> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Camden S.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Cecil MD.</i> | |
| 10. CITY OR TOWN OF DEATH <i>Elkton, Md. Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital, Elkton, . Md.</i> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Grooms-Man</i> | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Cecil</i> | |
| 13c. CITY OR TOWN <i>Elkton</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS | | 14. FATHER'S NAME FIRST MIDDLE LAST <i>David Adamson</i> | |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Almeta Lewis</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i> | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Haile Funeral Home, Camden S.C.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure, sepsis</i> 4920 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emphysema</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Gangrenous Right Leg, Anemia, Hypothermia, Liver Failure</i> | | | |
| 19a. DATE OF OPERATION <i>12/29/81</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrenous Right lower Leg</i> | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>December 10, 19 81</i> to <i>January 6, 19 82</i> , that (I) (we) lost saw the deceased alive on <i>January 6, 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>Charles M. Hensen MD</i> | | 22c. DATE SIGNED <i>1/6/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles M. HENSEN MD</i> | | 22e. ADDRESS <i>3 Mauldin Avenue North East, MD</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1/12/82</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Emanuel United Methodist Ch. Camden S.C.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Camden S.C.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Haile Funeral Home Camden S.C.</i> | | 25a. DATE REC'D BY REGISTRAR <i>JAN 18 1982</i> | |

BP

JAN 18 1982
State of Georgia

State of Georgia

1982

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1982

1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of all.

DHMH-1650M/1/81
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 1 / 4 4

REG. NO.

| | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. ARNETTE, SR | | | 2a. DATE OF DEATH MONTH DAY YEAR January 19, 1982 | | 2b. HOUR 9:20 am | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 30 1925 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | |
| 10. CITY OR TOWN OF DEATH Perry Point, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD. | | |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Conowingo | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William E. Arnette | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Marie Carpenter | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 11/43 - 10/53 267-52-3088 | | 17. INFORMANT ADDRESS V.A.M.C., Perry Point, Maryland 21902 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral infarction (c) Cerebral vascular accidents | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from November 5, 1981 to January 19, 1982 , the deceased and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | |
| 22b. SIGNATURE Julian Ocejio | | | | 22c. DATE SIGNED 1-19-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julian Ocejio, M.D. | | | | 22e. ADDRESS VAMC, Perry Point, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perry Point, Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va. | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James Jean Nathan | | |

MEDICAL CERTIFICATION

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1

BP



9:30am

January 19, 1982

AMERICAN

L.

WILLIAM

Henry Point, Md. VA Medical Center

207-52-3088

Cardiac arrest

Cerebral infarction

Cerebral vascular accident

x

January 19, 1982

January 19, 1982

SI

November 2

XXXXXXXXXXXXXXXXXXXX

1-19-82

x

VAMC, Henry Point, Md.

Julian Goff, M.D.

Leo A. Patterson & Son, Ferryville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 4 5 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY BATOGOWSKI | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1982 | | | |
| 3. SEX Male | | | | 4. RACE Caucasian | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR Nov 30, 1920 | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | | | |
| 7. BIRTH PLACE (STATE OR FOREIGN) Md. | | | | 8. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 10. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. | | | |
| 11. CITY OR TOWN OF DEATH Perry Point | | | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VA Medical Center | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md Baltimore | | | | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 15. STREET ADDRESS 2820 Hudson St. | | | | 16. FATHER'S NAME FIRST MIDDLE LAST Rudolph Batogowski | | | |
| 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stephanie Kitowski | | | | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES GIVE SERVICE) yes WW II | | | |
| 19. SOCIAL SECURITY NO 219-03-0576 | | | | 20. INFORMANT ADDRESS Stephanie Batogowski 2820 Hudson St. | | | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4/100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21f. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21h. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22c. I certify that (this hospital) attended the deceased from June 12 , 19 81 , to January 13 , 19 82 , that xxxxxx above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22d. SIGNATURE Avelina C. Hernandez, M.D. | | | | 22e. DEGREE M.D. | | 22f. DATE SIGNED 1-13-82 | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT) AVELINA HERNANDEZ, M.D. | | | | 22h. ADDRESS VAMC, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 1-16-82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION Baltimore City, Md. | |
| 24. FUNERAL DIRECTOR NAME Kaczorowski Funeral Home, Baltimore, Md. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 18 1982 | | | |

0:11am

January 13, 1962

ANTHONY

ANTHONY

VA Medical Center

Term Point

219-03-0270

Cardio-respiratory arrest

Acute myocardial infarction

XX

XXXXXX

32

January 13

71

June 12

XXXXXXXXXXXXXXXXXXXX

1-13-62

X

VMO, Terry Point, Md.

AVELINE HENRIKSEN, R.D.

JAN 18 1962

Macors and Funeral Home, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items 15a-13e per phone 1/25/82 STATE OF MARYLAND
 1- dad
 FOR dad
 STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 8 2 0 1 / 4 6
 REG. NO.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET MORGAN BOSWELL | | | 2a. DATE OF DEATH MONTH DAY YEAR January 9, 1982 | | 2b. HOUR 10:55a_M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 15 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Retired | | 12b. KIND OF BUSINESS OR INDUSTRY ---- | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Perry Point | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS V.A.M.C. | | 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Floyd Boswell | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Morgan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 7/18 - 7/19 215-54-4941 | | 17. INFORMANT ADDRESS V.A.M.C. Perry Point, Maryland 21902 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SICK SINUS NODE 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC OBSTRUCTIVE LUNG DISEASE, SCHIZOPHRENIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov 30 19 81 , to Jan 9 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan 9 19 82 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Klaus H. Huebner | | | | DEGREE M.D. | | 22c. DATE SIGNED 1-9-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KLAUS H. HUEBNER, M.D. | | | | 22e. ADDRESS VAMC PERRY POINT, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Culpeper Nat'l Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper Virginia | |
| 23e. DATE REC'D. BY REGISTRAR JAN 19 1982 | | | | 23f. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | |

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 1 7 4 7 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Bruce Henneberger Brockley | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18, 1982 | | 2b. HOUR 11 P.M. | | | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 4-17-1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Businessman | | 12b. KIND OF BUSINESS OR INDUSTRY Self | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Cecil 13c. CITY OR TOWN Earleville | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Holly Hill Farm | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Calvin Bruce | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Henneberger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 76-26-8723 | | 17. INFORMANT ADDRESS Gary Brockley -wife- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of the Liver 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Ca of the Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from June 80 , to 18 Jan 82 , that (I) (we) last saw the deceased alive on 18 Jan 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Wallace Obenshain M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | 22c. DATE SIGNED 1.20.82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain, M.D. | | | | | | 22e. ADDRESS Cecilton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 1-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem/ | | 23d. LOCATION CITY OR TOWN COUNTY STATE Earleville Cecil MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Edw. Fellows and Son, Cecilton, MD 21913 | | | | | | 25a. DATE AND BY REGISTRAR JAN 25 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

BP



NOTICE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY SP-6 JLM/STW

100-100000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 1 7 4 8

1. FOR
STATE
REGISTRAR

REG. NO.

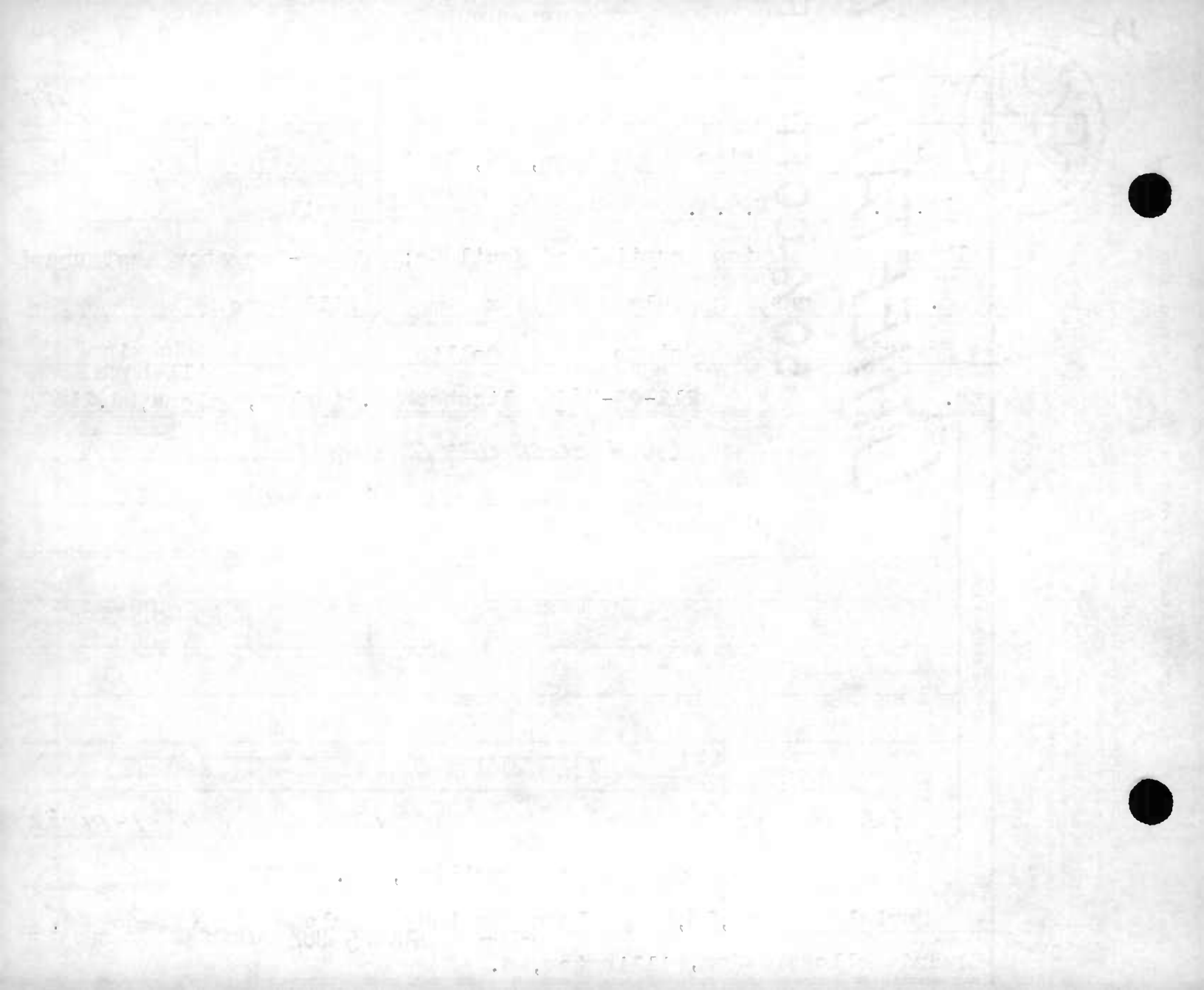
| | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Victoria H. Brooks</i> | | 2a. DATE OF DEATH MONTH <i>1</i> DAY <i>13</i> YEAR <i>82</i> | | 2b. HOUR <i>6:55 A</i> M |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH <i>Mar</i> DAY <i>29</i> YEAR <i>1901</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i> YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balt. Md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD. |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital of Cecil Co;</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner-Operator Restaurant</i> | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NOT IN HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Kent</i> | | 13c. CITY OR TOWN <i>Galena</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>Mill Lane</i> |
| 14. FATHER'S NAME FIRST <i>Edward</i> MIDDLE <i>Heinze</i> LAST <i>Heinze</i> | | 15. MOTHER'S MAIDEN NAME FIRST <i>Mollie</i> MIDDLE <i>Schwinn</i> LAST <i>Schwinn</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no.</i> | | 16b. SOCIAL SECURITY NO. <i>212-09-2656</i> | | 17. INFORMANT ADDRESS <i>Mill Lane</i> <i>Elizabeth J. Starkey, Galena, Md. 21635</i> |

| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1991</i> IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <i>Metastatic Liver carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASHD</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>J.A. Rosenfeld M.D.</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <i>1-14-82</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JoAnne Rosenfeld</i> | | 22e. ADDRESS <i>Cecilton, Md. 21913</i> | |

| | | | |
|----------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>Jan, 15, 82</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Galena Cemetery</i> | 23d. LOCATION CITY OR TOWN <i>Galena</i> COUNTY <i>Kent</i> STATE <i>Md.</i> |
| 24. FUNERAL DIRECTOR NAME <i>Edward Fellows & Son, Millington, Md.</i> ADDRESS <i>21651</i> | | 25. REGISTRAR'S SIGNATURE <i>JAN 15 1982</i> | |



BP _____
 DHMW-16 50M 1/81
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| FOR 1. STATE REGISTRAR | | | | | REG. NO. 8201749 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOLLIE B. CATRON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 8, 1982 | | | 2b. HOUR 2:37a.m. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 5, 1885 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13e. STREET ADDRESS 112 Bowling Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William - Saunders | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy - Brubb | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 229-05-8861 | | 17. INFORMANT ADDRESS Mr. Dennis L. Catron, Elkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Fractured Right hip Approximate interval between onset and death: 1-2 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| Fractured Right hip | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 74 , to January 8 19 82 , that (I) (we) last saw the deceased alive on December 31 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Charles M. Hensgen | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hensgen, M.D. | | | | | 22e. ADDRESS 3 Mauldin Avenue, North East, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Ramsey Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Norton, Virginia | | |
| 24. FUNERAL DIRECTOR Ralph E. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1982 25b. REGISTRAR'S SIGNATURE James Santhorn | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 1 7 5 0 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE WILLIAM CORDELL | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 11, 1982 | | 2b. HOUR 11:25AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 11, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner | | 12b. KIND OF BUSINESS OR INDUSTRY Coal | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Harford | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 2829 Henley Drive | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James William Cordell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vicey — Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWI | | 16b. SOCIAL SECURITY NO. 229 09 1902 | | 17. INFORMANT ADDRESS Donald J. Cordell, Bel Air, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease (c) Contributed to by empyema | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 2, 1981 to January 11, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Roy W. Chesnut, Jr. | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-11-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROY W. CHESNUT, M.D. | | | | 22e. ADDRESS VA Medical Center, Perry Point, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 18) Burial | | 23b. DATE Jan. 14, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aldino Harford Md. | |
| 24. FUNERAL DIRECTOR NAME Howard McComas III | | | | ADDRESS Funeral Home, Abingdon, Md. | | 35a. DATE OF REGISTRATION JAN 15 1982 | |

2

RECEIVED

MAIL ROOM

January 11, 1964

Dear Sir:

Very truly yours,

John F. Kennedy

President of the United States

Washington, D.C.

Enclosed are:

1. Copy of the report of the

Commission on the Assassination of

President John F. Kennedy

dated September 24, 1963.

2. Copy of the report of the

Commission on the Assassination of

President John F. Kennedy

dated November 1, 1963.

Very truly yours,

John F. Kennedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

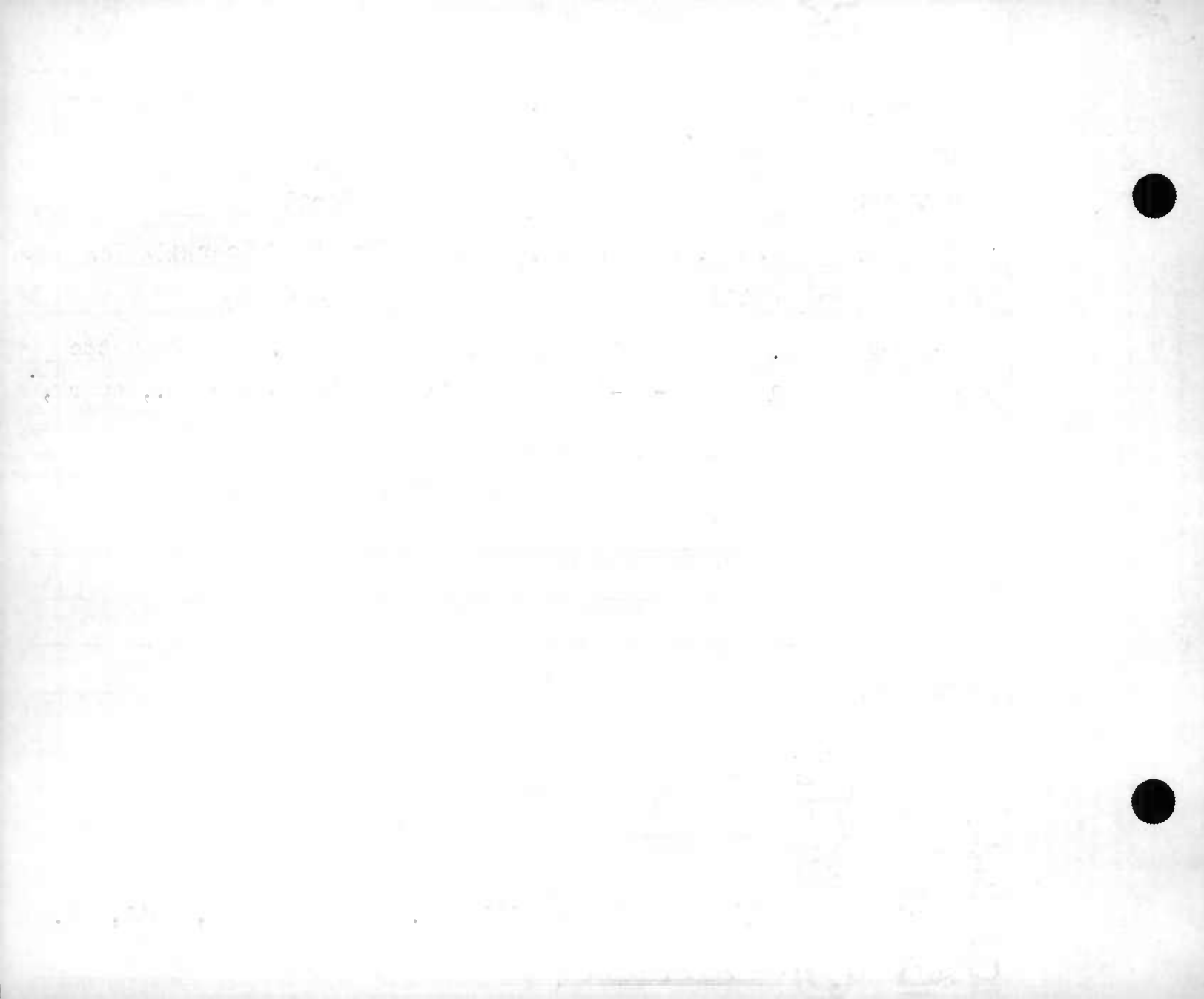
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 20M
(VRA 15, 4) 7/78

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 / 5 1 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Robert J DAVIS | | | | 1 - 29-82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| MALE | | WHITE | | 12 22 91 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Maryland | | USA | | 91 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| ELKTON MD | | LAURELWOOD NURSING Center. | | Cecil MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Trust Officer | | Wilm. Trust Emp. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| 13a. STATE | | 13b. COUNTY | | 13c. STREET ADDRESS | |
| DEL. | | New Castle | | 27 Center St. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Harry H. Davis | | Anna C. Jaquette | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | 222-10-1528 | | Edna Hillyard 40 Center St., Newark, Del. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Renal failure</u> | | | | | |
| 4409 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>Generalized arteriosclerosis</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 3</u> , 19 <u>80</u> , to <u>1-29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-29</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Donald C. Edgren M.D.</u> | | | | 1-29-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| DONALD C. EDGREN M.D. | | 721 BRIDGE ST | | | |
| 721 BRIDGE ST, ELKTON, MD. | | ELKTON, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 2/1/82 | | Cherry Hill Cem. | |
| | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | Cherry Hill, Cecil, Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Robert T. Jones | | | | FEB 9 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | <u>Marie Jones</u> | |

BP



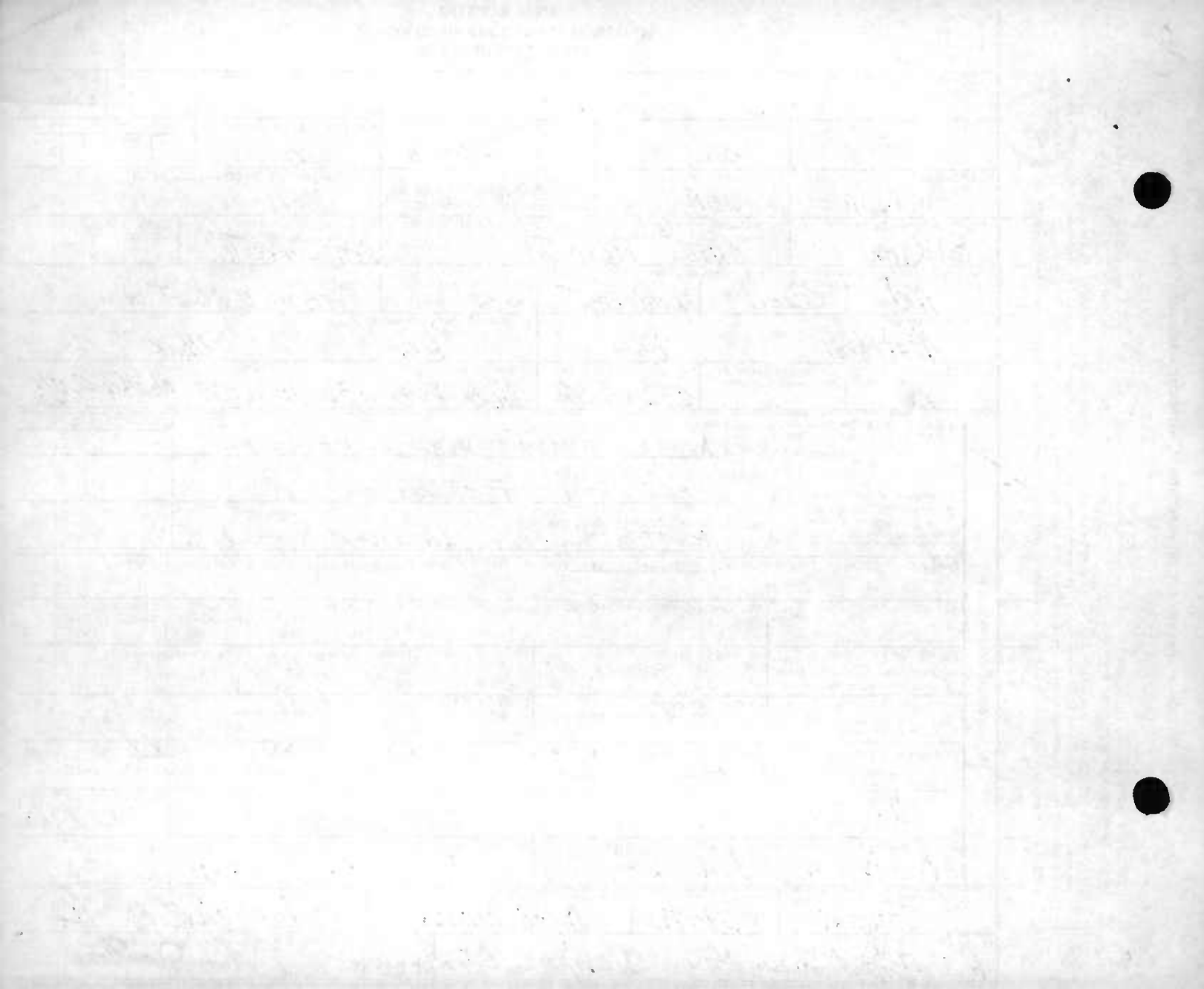
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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) B ranson C Doss | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 26 82 | | | 2b. HOUR 2:38p M | |
| 3 SEX Male | | 4 RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 2-14-1913 | | 6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 10 CITY OR TOWN OF DEATH EIKTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN North East | | 13e. STREET ADDRESS 13 W. WALNUT ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Matthew Doss | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA MINK | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 242-05-9175 | | 17. INFORMANT ADDRESS NORA Doss 13 W. WALNUT ST NorthEast Md 21901 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYO CARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSES DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC CARDIOMYCLAR ALS. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-22 19 82, to 1-86 19 82, that (I) (we) lost saw the deceased alive on 1-22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Roland Najera M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roland Najera M.D. | | | | | | 22e. ADDRESS EIKTON, Md 21921 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-29-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Oxford, Chester Co, Pa | | | |
| 24. FUNERAL DIRECTOR NAME Rita Ford Funeral Home | | | | | | ADDRESS Chesapeake City Md | | 15. DATE REC'D. BY REGISTRAR FEB 3 1982 | |
| 75. REGISTRAR'S SIGNATURE | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Everett Roy England | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 15, 1982 | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 4, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 964 Calvert Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 964 Calvert Rd. | | |
| 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Rising Sun | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clifford England | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie May Clark | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-16-0964 | | 17. INFORMANT ADDRESS (SEE) C. Clifford England Box 230 NorthEast Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 4 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-80 , 19 68 , to 1-15 , 19 82 , that (I) (we) lost saw the deceased alive on 1-15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Neil R Taylor MD DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-15-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor | | | | | 22e. ADDRESS Rising Sun, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 18, 82 | | 23c. NAME OF CEMETERY OR CREMATORY Rosebank Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Calvert Cecil Co. Md. | | |
| 24. FUNERAL DIRECTOR REH Muller | | | 25a. DATE RECEIVED BY REGISTRAR JAN 20 1982 | | 25b. NAME OF REGISTRAR John J. [Signature] | | | | |

MAILED 11/11/10

RECEIVED 11/11/10

11-11-10

11-11-10

11-11-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8201754 | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------|--|--|--|
| FOR 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CECIL E. Ewing | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 11 1982 | | | | 2b. HOUR 815 A M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 18, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil County, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner - General Store | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 364 Fair Hill Drive | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Amos S. Ewing | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora McCauley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-26-5292 | | 17. INFORMANT ADDRESS Mrs. Edna M. Ewing, 364 Fair Hill Drive, Elkton, Md. 21921 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular disease 4379 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with supranuclear palsy DUE TO, OR AS A CONSEQUENCE OF (c) 2 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Scleroderma with CRST syndrome | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to Jan. 11 , 19 82 , that (I) (we) last saw the deceased alive on Jan. 10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Edgar E. Folsom | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED Jan. 11, 1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folsom | | | | 22e. ADDRESS ELKTON, Md 21921 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Friends Burial Ground | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Calvert, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Edgar E. Folsom ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Witten | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 8201755 | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED M. GALLAHER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1982 | | 2b. HOUR 2:45 A | | | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 14, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria- School System | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 291 Russell Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William - Thompson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna - Brush | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 216-30-7054 | | 17. INFORMANT ADDRESS Mrs. Margaret Perkins, Elkton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.H.F. (Congestive heart failure) 4409 DUE TO, OR AS A CONSEQUENCE OF (b) generalized atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) fx of (b) iliac vessel. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 72 , to 1/27 , 19 82 , that (I) (we) last saw the deceased alive on 1/27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Jui-Chih Hsu | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chih Hsu, M.D. | | | | | | 22e. ADDRESS 223 W. Main St. Elkton, Md. 21921 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cherry Hill, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Ralph E. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 5 6 | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HALEY J. GILL | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 21 82 | | 2b. HOUR 7-37A | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 24, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland 13b. COUNTY Cecil 13c. CITY OR TOWN Elkton | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 102 Kist Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jim - Ward | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy S. Adkins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 236-32-4384 | | 17. INFORMANT ADDRESS Mrs. Lottie V. Biggs, Elkton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia COPD | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) ASHD | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) G.I. Bleeding | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-82 , 19____, to 1/21/82 , 19____, that (I) (we) last saw the deceased alive on 1/20/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Gyanantilal K. Patel DEGREE MD | | | | 22c. DATE SIGNED 1/25/82 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K PATEL MD | | | | 22f. ADDRESS 123 Singers Ave ELKTON MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkton, Md. | |
| 24. FUNERAL DIRECTOR Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 4 0 1982 REGISTRAR'S SIGNATURE [Signature] | | | |

930-15-4346 978, Lucille V. Bishop, Lincoln, Neb.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

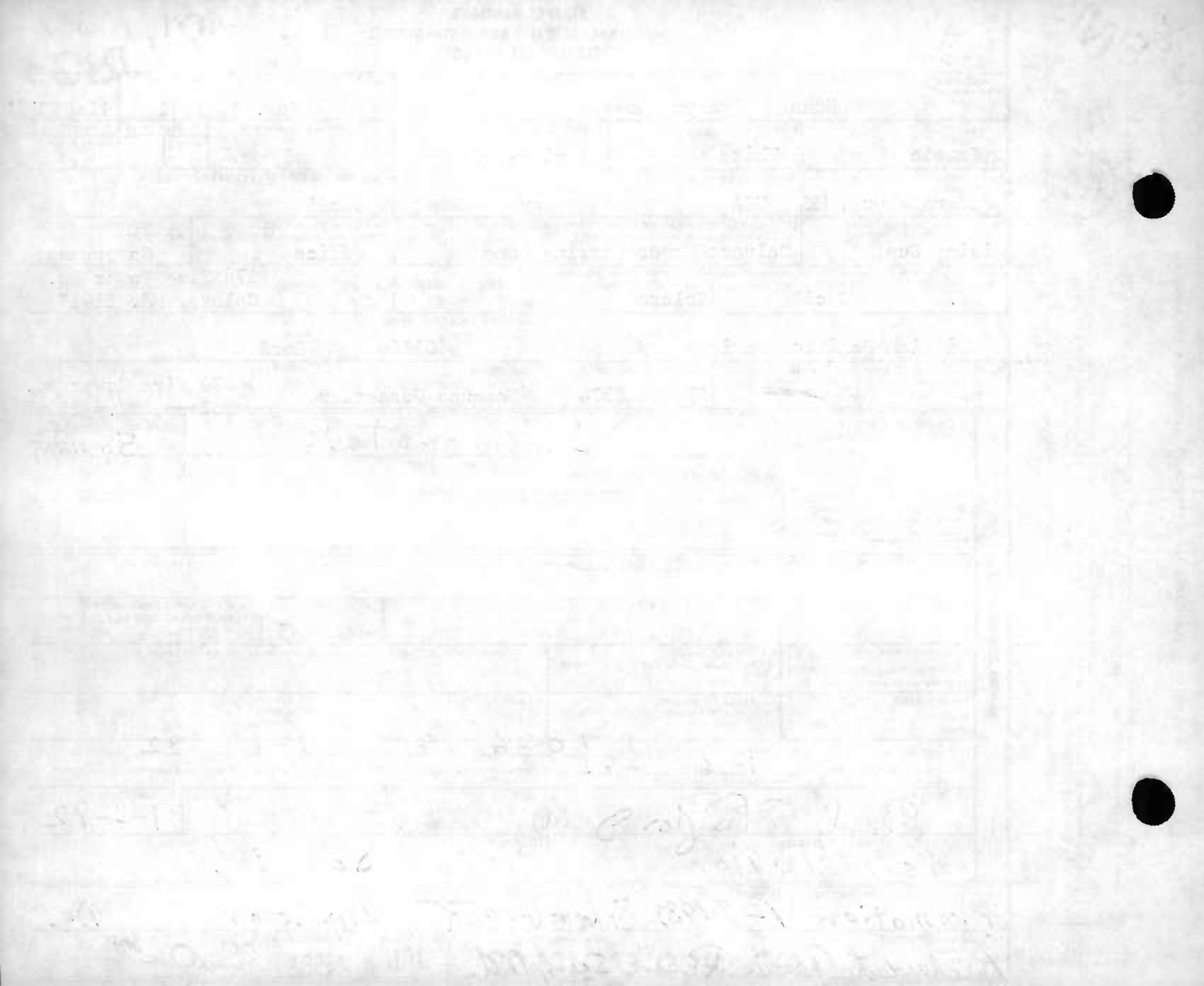
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 5 7 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edna Evelyn Goebel | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 6, 1982 | | 2b. HOUR 11:05 A.M. | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 10-18-1895 | | 6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalsburg, Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10 CITY OR TOWN OF DEATH Rising Sun, | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office | | 12b. KIND OF BUSINESS OR INDUSTRY Government | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Colora | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Hamilton Davis | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ollie Lord | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 578 66 8874 | | 17 INFORMANT ADDRESS Rozanne Hostetter, 876 Fire Tower Rd. Colora, Md. 21917 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 1990 Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-26-81 to 1-6-82, that (I) (we) lost saw the deceased alive on 1-6-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Neil Taylor MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-6-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor | | | | 22e. ADDRESS Rising Sun, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1-7-1982 | | 23c. NAME OF CEMTERY OR CREMATORY Silverbrook | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington Del | |
| 24 FUNERAL DIRECTOR NAME Richard L. Goodie | | | | ADDRESS Rising Sun, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1982 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Rozanne Hostetter | |

BP.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 2 0 1 7 5 8 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|--|------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Lillian R. Grotz | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 1 DAY 29 YEAR 1982 | | | 2b. HOUR 6 a.m. | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH Jan DAY 12 YEAR 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County | |
| 10. CITY OR TOWN OF DEATH Georgetown | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Public Safety | |
| 13a. STATE MD | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Georgetown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 15 Driftwood Lane | | | |
| 14. FATHER'S NAME FIRST Henry MIDDLE W. LAST Grotz | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Mueller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 161-03-8165-A | | 17. INFORMANT ADDRESS Carol Wilson, 15 Driftwood Lane, Georgetown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct | | | | | | | | | | | |
| 4100 } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) Severe Coronary Artery Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Dehydration | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Juan C. Gonzalez-Vitale | | | | TITLE (SPECIFY) M.D. | | | | DATE SIGNED 1/29/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Juan C. Gonzalez-Vitale, M.D. ADDRESS Union Hospital of Cecil County | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 1-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington N.C. Del. | | | |
| 24. FUNERAL DIRECTOR NAME Edw. Fellows and Son ADDRESS Cecilton MD 21913 | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



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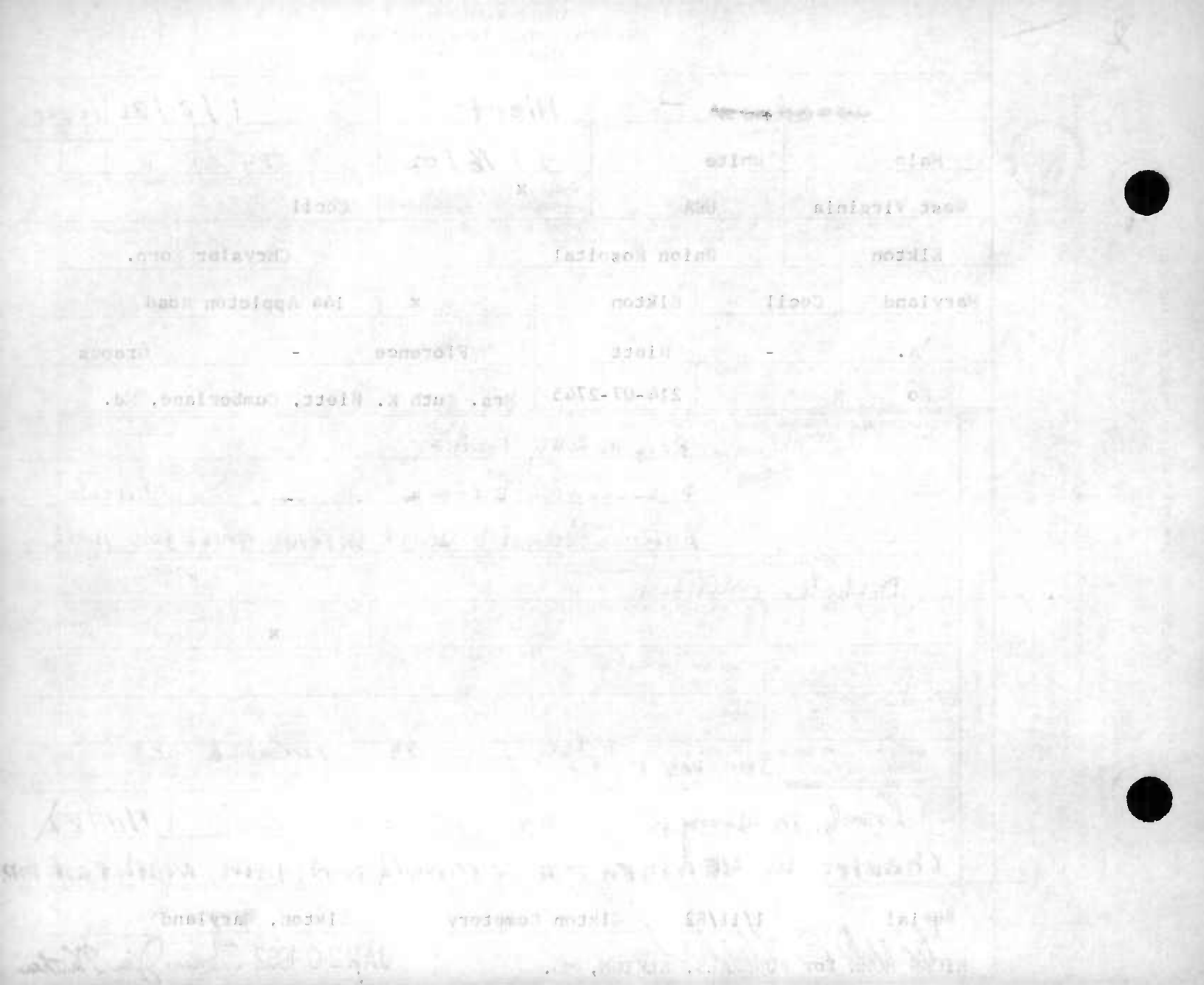
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 82 01759 | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/8/82 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wood woodson - Hiatt | | | | 2b. HOUR 12 30 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4/16/02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chrysler Corp. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | |
| 14. FATHER'S NAME FIRST MIDDLE LAST A. - Hiatt | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence - Grapes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-07-2745 | | 17. INFORMANT ADDRESS Mrs. Ruth K. Hiatt, Cumberland, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema | | | | | | | 1 week |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease, Pneumonia | | | | | | | 1 week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1979 to January 8, 1982, that (I) (we) last saw the deceased alive on January 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles M. Hays | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Hays M.D. | | | | 22e. ADDRESS 3 Maryland Avenue, North East, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkton, Maryland | |
| 24. FUNERAL DIRECTOR Ralph E. Hicks ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE James J. Keith | | | |



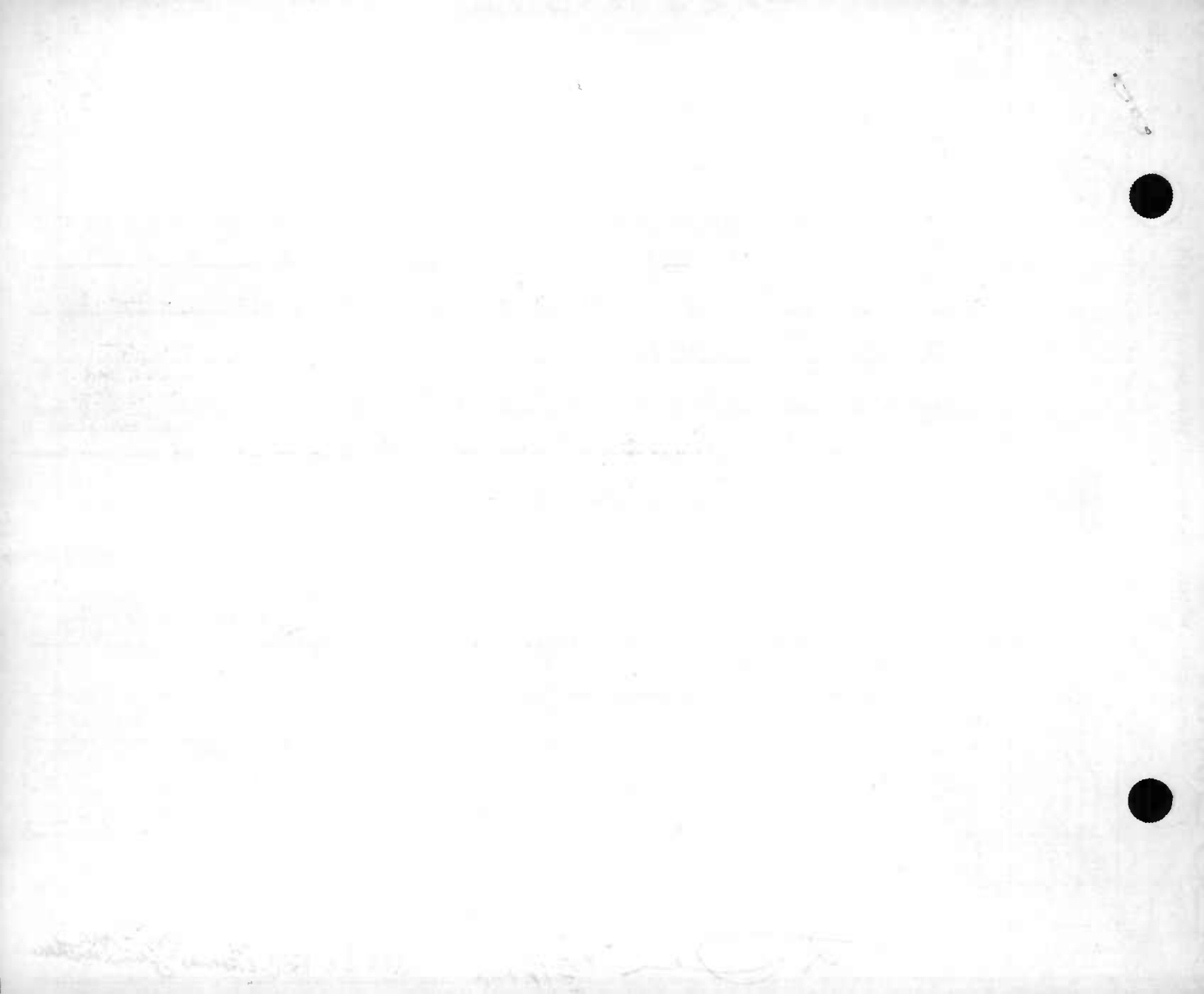
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or designated autopsy must be performed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 / 6 0 | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EMMA | | 2a. DATE OF DEATH MONTH 1 DAY 19 YEAR 82 | | | | | |
| 3 SEX Female | | 2b. HOUR 9 P M | | | | | |
| 4 RACE C | | 6 AGE (IN YEARS LAST BIRTHDAY) 83 | | | | | |
| 5. DATE OF BIRTH MONTH 6 DAY 14 YEAR 1888 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC | | 9 BALTIMORE CITY OR COUNTY OF DEATH CECIL MD. | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | 12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | | | | |
| 10 CITY OR TOWN OF DEATH ELKTON | | 12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE | | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAURELWOOD NURSING CENTER | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | | | |
| 13a. STATE Md. | | 13b. CITY OR TOWN DAMASCUS | | | | | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 26900 Overlook St. | | | | | |
| 14. FATHER'S NAME FIRST JOHN MIDDLE STOREY LAST STOREY | | 15. MOTHER'S MAIDEN NAME FIRST EMMA MIDDLE STUMP LAST XXXXXX | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN | | 16b. SOCIAL SECURITY NO 036-22-9255 | | | | | |
| 17. INFORMANT ADDRESS DAMASCUS, Md. | | 17. INFORMANT RUBY HOPKINS SURETTE 26900 OVERLOOK ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASHD - Pulmonary Emboli Suspected 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Chc UTE - DUE TO, OR AS A CONSEQUENCE OF (c) Chc UTE - | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | |
| 21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 1981 to 1/19/82 , that (I) (we) last saw the deceased alive on 1/14/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jayantilal K. Patel MD DEGREE MD | | 22c. DATE SIGNED 1/20/82 | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD | | 22c. ADDRESS 123 SINGERLY AVE ELKTON MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/22/82 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY National Memorial Park | | 23d. LOCATION CITY OR TOWN Falls Church, Va. COUNTY VA. STATE VA. | | | | | |
| 24. FUNERAL DIRECTOR NAME George J. ... ADDRESS 259 E Main St Elkton | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1982 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMM - 16 50M 1/76
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 1 7 6 1 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank P. Hopkins | | | | | | 01/02/82 | | | | | | 10:10A _M | |
| 3. SEX male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 01 25 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 years YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hosp Hospital of Cecil County | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY Bldg. | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 145 East Main Street | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Hopkins | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zella Joseph | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT ADDRESS Dorothy L. Hopkins Elkton, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>15 years</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Edgar E. Folk III | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar E. Folk III, M.D. | | | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY North East Meth. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md. | | | |
| 24. FUNERAL DIRECTOR NAME John P. Clark | | | | | | ADDRESS North East, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1- FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Anne R. Kaehn | | | | | | 2a DATE OF DEATH MONTH DAY YEAR 01 - 31 - 82 | | 2b HOUR 10:10 PM | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 01 11 95 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 10 CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurelwood Nursing Center | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice-President | | 12b KIND OF BUSINESS OR INDUSTRY Dept. Store | |
| 13a STATE Maryland | | 13b COUNTY Cecil | | 13c CITY OR TOWN Chesapeake City | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 16 North Bluff Road | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Camburn | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Shoemaker | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | 16b SOCIAL SECURITY NO. 222-07-2760A | | 17. INFORMANT ADDRESS Mr. George C. Kaehn Galena, Maryland | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest.</i> 1590 } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cervical Arterio Borel - Redaction</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>1/17</i> 19 <i>82</i> to <i>1/31</i> 19 <i>82</i> that (I) <input checked="" type="checkbox"/> saw the deceased alive on above, (I) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph G. Lanzi</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. Lanzi M.D. | | | | 22e. ADDRESS 721 Bridge Street, Elkton, Md. 21921 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-3-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington New Castle Delaware | | | |
| 24 FUNERAL DIRECTOR NAME <i>Ralph E. Hicks</i> ADDRESS Hicks Home for Funerals, Elkton, Maryland | | | | | | | | | |

MEDICAL CERTIFICATION



| | | | | | |
|--------------|----------|------|-----------|--------|-----|
| 21 - 31 - 52 | 10:10 | John | White | Female | Age |
| 22 | 01 11 52 | USA | Tennessee | Female | Age |
| 23 | 01 11 52 | USA | Tennessee | Female | Age |
| 24 | 01 11 52 | USA | Tennessee | Female | Age |
| 25 | 01 11 52 | USA | Tennessee | Female | Age |
| 26 | 01 11 52 | USA | Tennessee | Female | Age |
| 27 | 01 11 52 | USA | Tennessee | Female | Age |
| 28 | 01 11 52 | USA | Tennessee | Female | Age |
| 29 | 01 11 52 | USA | Tennessee | Female | Age |
| 30 | 01 11 52 | USA | Tennessee | Female | Age |

Handwritten notes:
222-47-2700 W. George C. Leann, Calais, Maryland
222-47-2700 W. George C. Leann, Calais, Maryland
222-47-2700 W. George C. Leann, Calais, Maryland

Handwritten notes:
Joseph C. Leann, M.D.
222-47-2700 W. George C. Leann, Calais, Maryland
222-47-2700 W. George C. Leann, Calais, Maryland
222-47-2700 W. George C. Leann, Calais, Maryland

Handwritten notes:
2-3-1982
Wilmington New Castle Delaware
Wilmington, Delaware
Wilmington, Delaware
Wilmington, Delaware

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 1 7 6 3

1 - FOR
STATE
REGISTRAR

REG. NO.

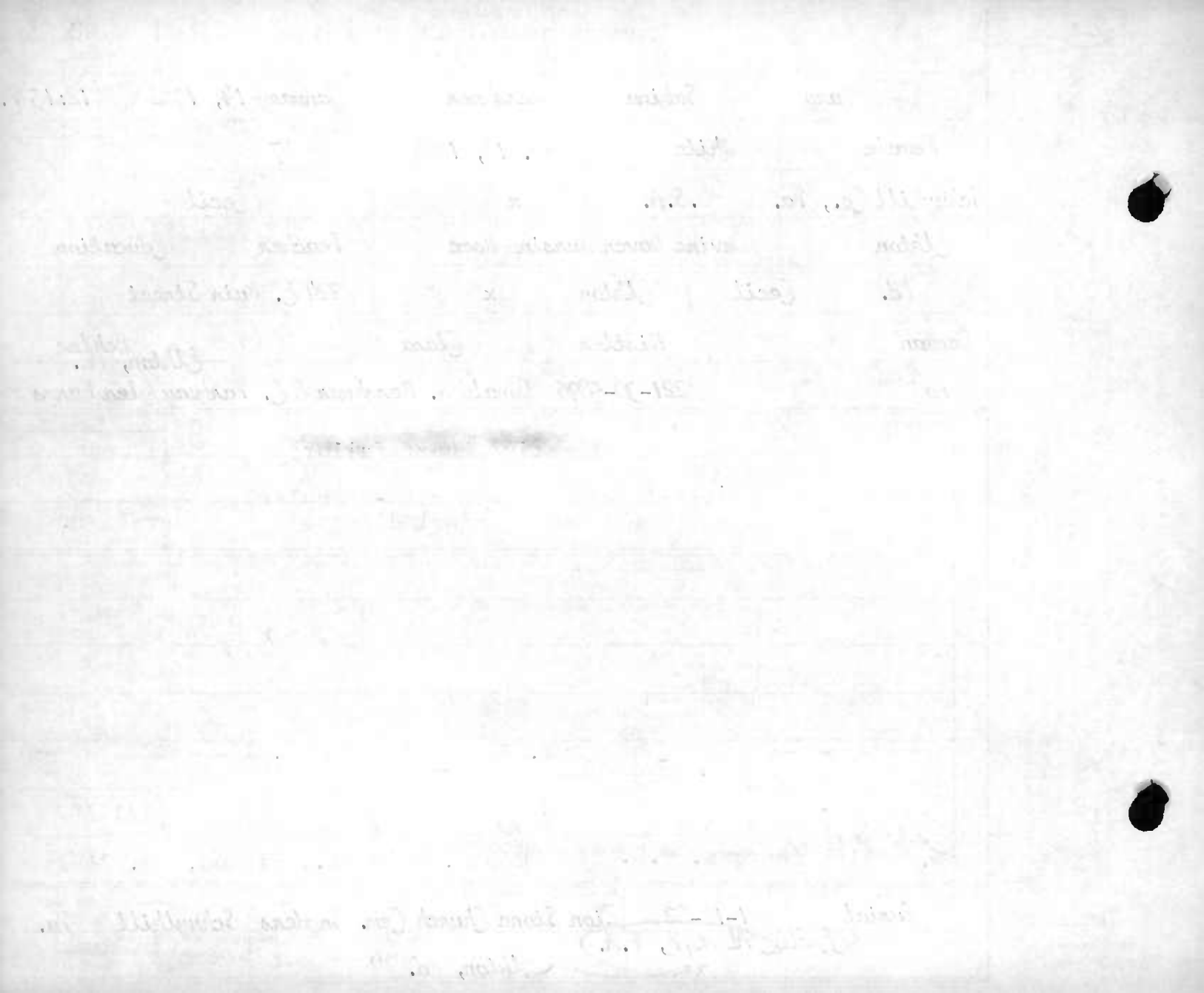
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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mary Sabina Kershner</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 14, 1982</i> | | 2b. HOUR MIN. <i>12:15 P.</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 15, 1894</i> | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>87</i> | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Schuylkill Co., Pa.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> | | MD | | |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF DECEASED IN A HOSPITAL, STREET ADDRESS) <i>Devine Haven Nursing Home</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i> | | |
| 12b. KIND OF BUSINESS OR INDUSTRY <i>Education</i> | | 13a. STATE <i>Md.</i> | | 13b. COUNTY <i>Cecil</i> | | |
| 13c. CITY OR TOWN <i>Elkton</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>224 E. Main Street</i> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Deymann Kistler</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara Berler</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i> | | |
| 16b. SOCIAL SECURITY NO. <i>221-30-5896</i> | | 17. INFORMANT ADDRESS <i>Donald W. Kershner 8 E. Parkway Glen Farms Elkton, Md.</i> | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4049 Congestive heart failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } <i>Arteriosclerotic cardio-vascular</i> DUE TO, OR AS A CONSEQUENCE OF <i>renal disease</i> <i>over 1 yr.</i> (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (we) attended the deceased from <i>Aug. 7, 1981</i> to <i>Jan. 14, 1982</i> , that (I) (we) saw the deceased alive on <i>Jan. 13, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE <i>S. Ralph Andrews</i> | | DEGREE <i>M.D.</i> | | 22c. DATE SIGNED <i>1/15/82</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>S. Ralph Andrews, M.D.</i> | | 22e. ADDRESS <i>233 E. Main St., Elkton, Md. 2192</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-18-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Zion Stone Church Cem.</i> | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sniders Schuylkill Pa.</i> | | 24. FUNERAL DIRECTOR NAME ADDRESS <i>SEE FUNERAL HOME, P.A. Elkton, Md.</i> | | | | |
| 25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



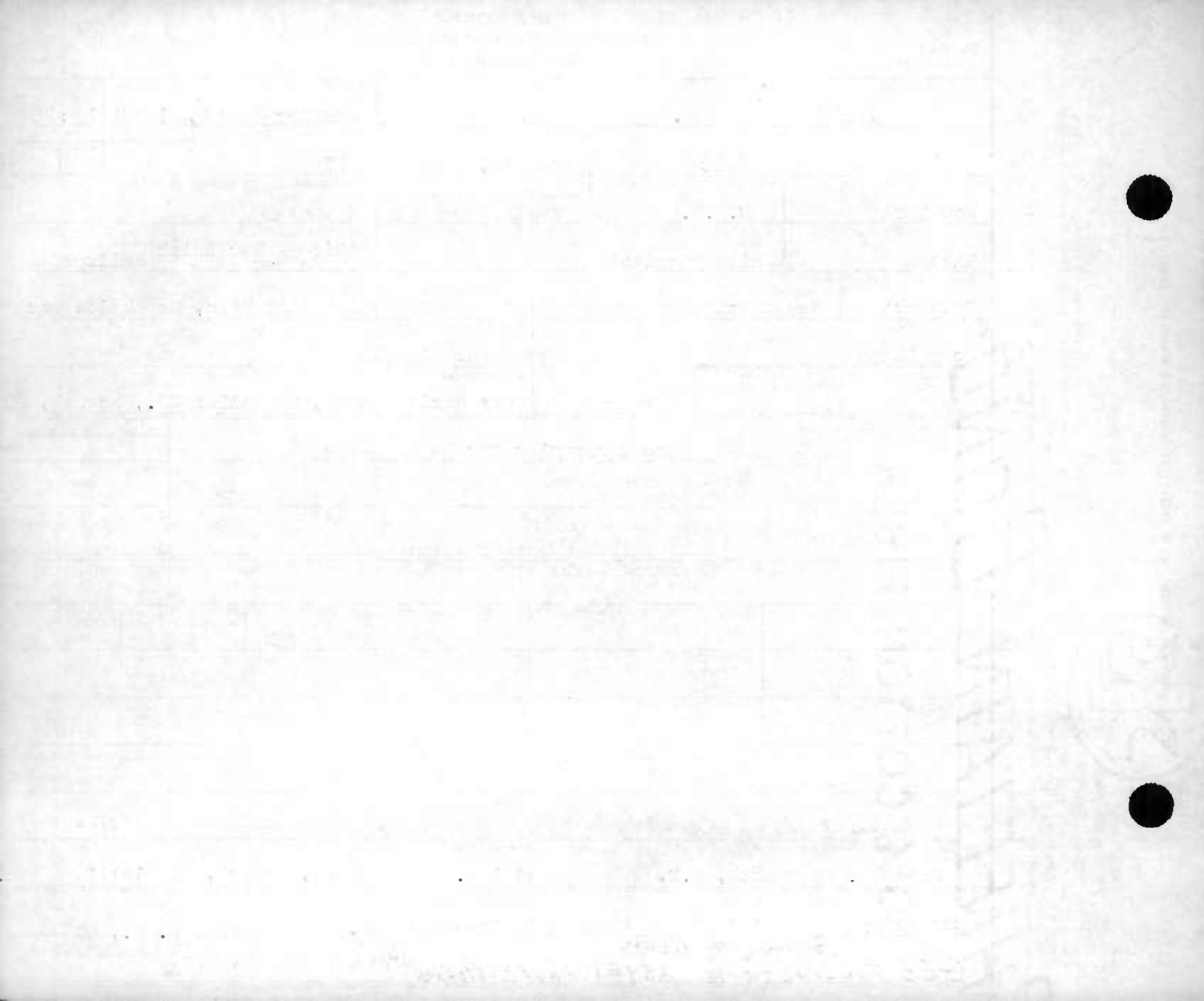
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.69
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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 0 1 7 6 4 | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|--|-------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Archie J. Lloyd | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 14, 1982 | | | | 2b. HOUR 10:30 P | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR March 12, 1904 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired Machinist Helper | | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware 13b. COUNTY New Castle 13c. CITY OR TOWN Newark | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 24 Keller Road, Brookside Park | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Lloyd | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Elmoyle | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 222-09-9696 | | | 17. INFORMANT ADDRESS Rose Marie Spence, 24 Keller Rd., Newark, DE | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Stroke 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October , 19 81 , to January , 19 82 , that (I) (we) last saw the deceased alive on January 14, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE James R. Dearworth | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/15/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Dearworth, M.D. | | | | | | 22e. ADDRESS 167 W. Main Street, Newark, DE 19711 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/18/82 | | | 23c. NAME OF CEMETERY OR CREMATORY Hockessin Crematory Co. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hockessin, N. C., DE | | | | | | |
| 24. FUNERAL DIRECTOR NAME Edward McElwain ADDRESS GEE FUNERAL HOME 259 E MAIN ST ELKTON | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1982 | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | |

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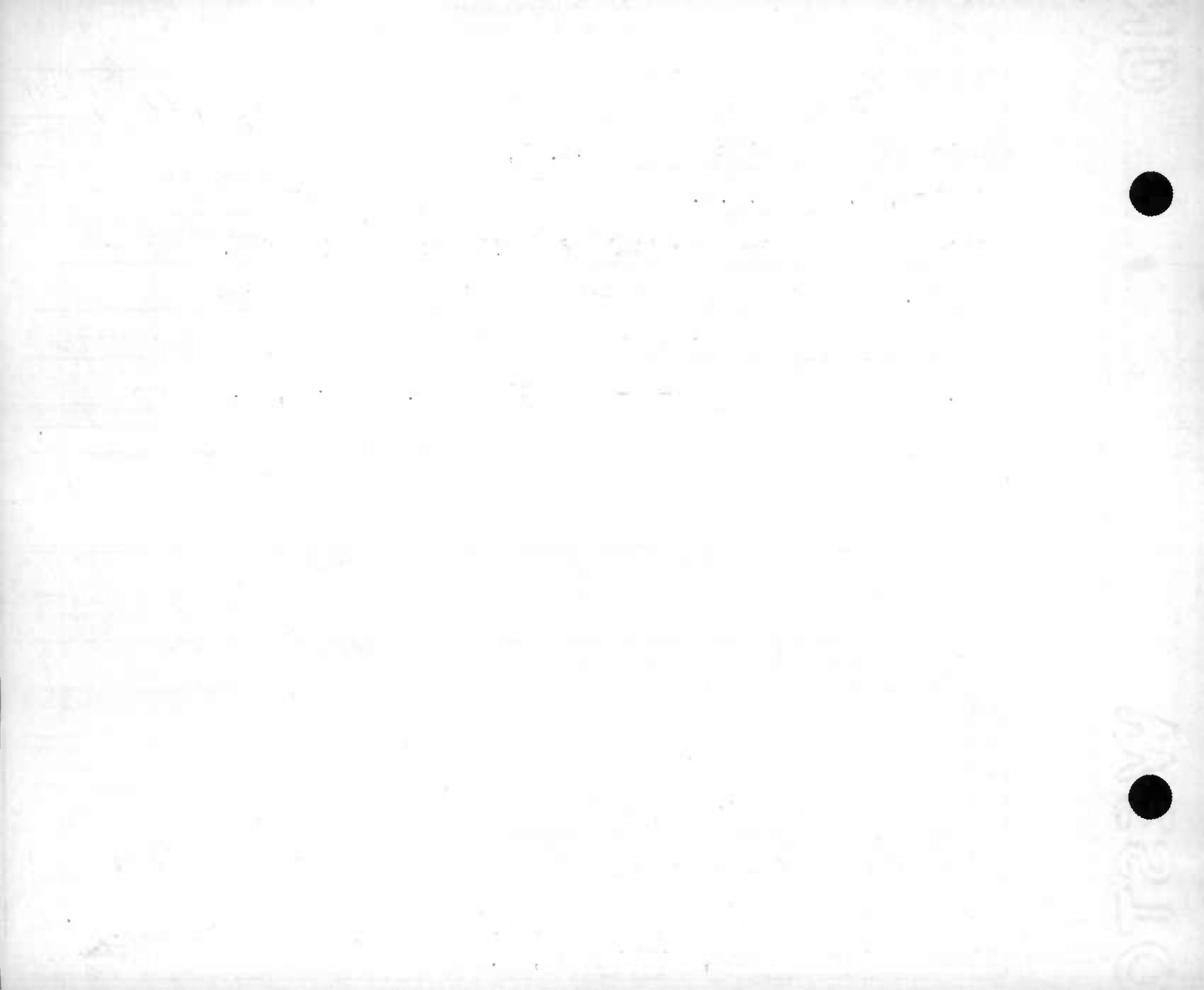
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 / 6 5 | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>ROY C. Mitchell, Jr.</u> | | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>7</u> YEAR <u>82</u> 2b. HOUR <u>7:45</u> AM <u>A</u> | | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>Feb.</u> DAY <u>1</u> YEAR <u>1902</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ridgley, Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Elkton</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Union Hospital of Cecil Co;</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farming Ret.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Kent</u> | | 13c. CITY OR TOWN <u>Kennedyville</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST <u>Herman</u> MIDDLE <u></u> LAST <u>Mitchell</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>Ida</u> MIDDLE <u></u> LAST <u>Deitwiller</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No.</u> (IF YES, GIVE WAR OR DATES) <u></u> | | | |
| 16b. SOCIAL SECURITY NO. <u>214-20-1308</u> | | 17. INFORMANT ADDRESS <u>Mildred R. Mitchell, as above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular arrest.</u> <u>4275</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <u>82</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> , 19 <u>82</u> , to <u>1-7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Jo Ann Rosenfeld</u> DEGREE <u>MD</u> | | | | 22c. DATE SIGNED <u>1-7-82</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jo Ann Rosenfeld M.D.</u> | |
| 22e. ADDRESS <u>Cecilton, Md.</u> | | | | 22f. ADDRESS <u>Cecilton, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u> | | 23b. DATE <u>1/9/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Galena Kent Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Edward Fellows & Son, Millington, Md.</u> | | 24b. ADDRESS <u>21651</u> | | 24c. DATE READ BY REGISTRAR <u>JAN 19 1982</u> | | 24d. REGISTRAR'S SIGNATURE <u>Jan. Nathan</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 7. REG. NO. 8201766 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Clifford Owens | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1/20/82 | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1/19/10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | 7b. HOUR 3:00 P.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Del. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equip. Tester | | 12b. KIND OF BUSINESS OR INDUSTRY Ordinance | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Scott | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE | | 17. INFORMANT Jane M. Owens | | 17. ADDRESS 15 Joseph Gallaher St. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardio Pulmonary arrest possibly 2nd to Ac. Myo. Infarct. DUE TO, OR AS A CONSEQUENCE OF (b) CHF, primarily (c) Ventricle Failure DUE TO, OR AS A CONSEQUENCE OF (c) AS EVD + Diabetes Mellitus. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-11-82 to 1-20-82, that (I) (we) lost the deceased alive on 1-20-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Ernesto Ablang | | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ernesto Ablang | | | | 22e. ADDRESS 200 Bow St. Elkton Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Head of Christiana | | 23d. LOCATION CITY OR TOWN COUNTY STATE Newark Del. Newcastle Del. | | | | |
| 24. FUNERAL DIRECTOR NAME Gee Funeral Home | | | | 24. ADDRESS 259 E. Main St. Elkton, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 25 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 0 1 7 6 7 | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Earle C. Pattison | | | | January 10, 1982 | | | | 8:10P M | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 19, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. Medical Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 8310 Nightingale Drive | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 114 18 1488 | | 17. INFORMANT ADDRESS VAMC, Perry Point, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1619 IMMEDIATE CAUSE (a) Carcinoma larynx with secondaries DUE TO, OR AS A CONSEQUENCE OF (b) Organic brain syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-10-82 to 1-10-82, that (we) lost the deceased alive on 1-10-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Purushothaman | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 1-10-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDROTH V. PURUSHOTHAMAN, M.D. | | | | 22e. ADDRESS VAMC, Perry Point, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE Jan. 11, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Georgetown Sch. Medicine | | 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md. | | | | 25a. DATE RECD. BY REGISTRAR JAN 18 1982 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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J. A. Patterson & Son, Troyville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Daniel J. Quinn, Jr. | | | | | 2a. DATE OF DEATH MONTH 01 DAY 15 YEAR 82 | | | 2b. HOUR 11:48AM | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH 07 DAY 28 YEAR 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Kent Cecil MD. | | | | |
| 10. CITY OR TOWN OF DEATH Kennedyville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital, Elkton, MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | |
| 13a. STATE MD | | | | | 13b. CITY OR TOWN Kennedyville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 47 | |
| 14. FATHER'S NAME FIRST Daniel MIDDLE Joseph LAST Quinn, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Cornelius | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | | 16b. SOCIAL SECURITY NO. 213-22-5647 | | 17. INFORMANT ADDRESS Suzanne T. Quinn, as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J. A. Rosenfeld, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-15-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. A. Rosenfeld, M.D. | | | | | | 22e. ADDRESS Cecilton, Md. 21913 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/18/82 | | 23c. NAME OF CEMETERY OR CREMATORY Kennedyville Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Kennedyville, Kent, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Edward Fellows & Son, Millington, Md. | | | | | | 25. DATE REC'D. BY REGISTRAR JAN 25 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

MEDICAL CERTIFICATION

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Traveler's Bureau, Inc.

Washington

Male

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1. Kennedyville

Union Hospital, Clinton, MO

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12. Kent, Kennedyville

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1. A. Kennedyville, N.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) MARGARET B. Rhodes | | 2a. DATE OF DEATH MONTH 1 DAY 16 YEAR 82 | | 2b. HOUR 115 P |
| 3. SEX Female | 4. RACE Negro | 5. DATE OF BIRTH MONTH Apr. DAY 1 YEAR 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County |
| 10. CITY OR TOWN OF DEATH Elkton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Del. | | 13b. COUNTY W.C. | 13c. CITY OR TOWN Middletown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST Robert MIDDLE Briscoe LAST | | 15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE Briscoe LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 221-16-9459 | 17. INFORMANT Catherine Harris, Middletown, Del. | |

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) suicide 7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple decubitus ulcers (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 12/01 , 19 81 , to 1/16 , 19 82 , that (1) (we) lost saw the deceased alive on 1/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Kenneth Lewis, MD | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 1/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Lewis, M.D. | | 22e. ADDRESS Middletown, Del | |

| | | | |
|------------------------------------------------------------------------------------------|-----------------------------|------------------------------------------------------------|---------------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/21/82 | 23c. NAME OF CEMETERY OR CREMATORY Dale Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Middletown, Delaware |
| 24. FUNERAL DIRECTOR NAME Edw R Bell ADDRESS 909 Poplar St., Wilm. Del. | | 25a. RECEIVED BY REGISTRAR FEB 2 1982 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

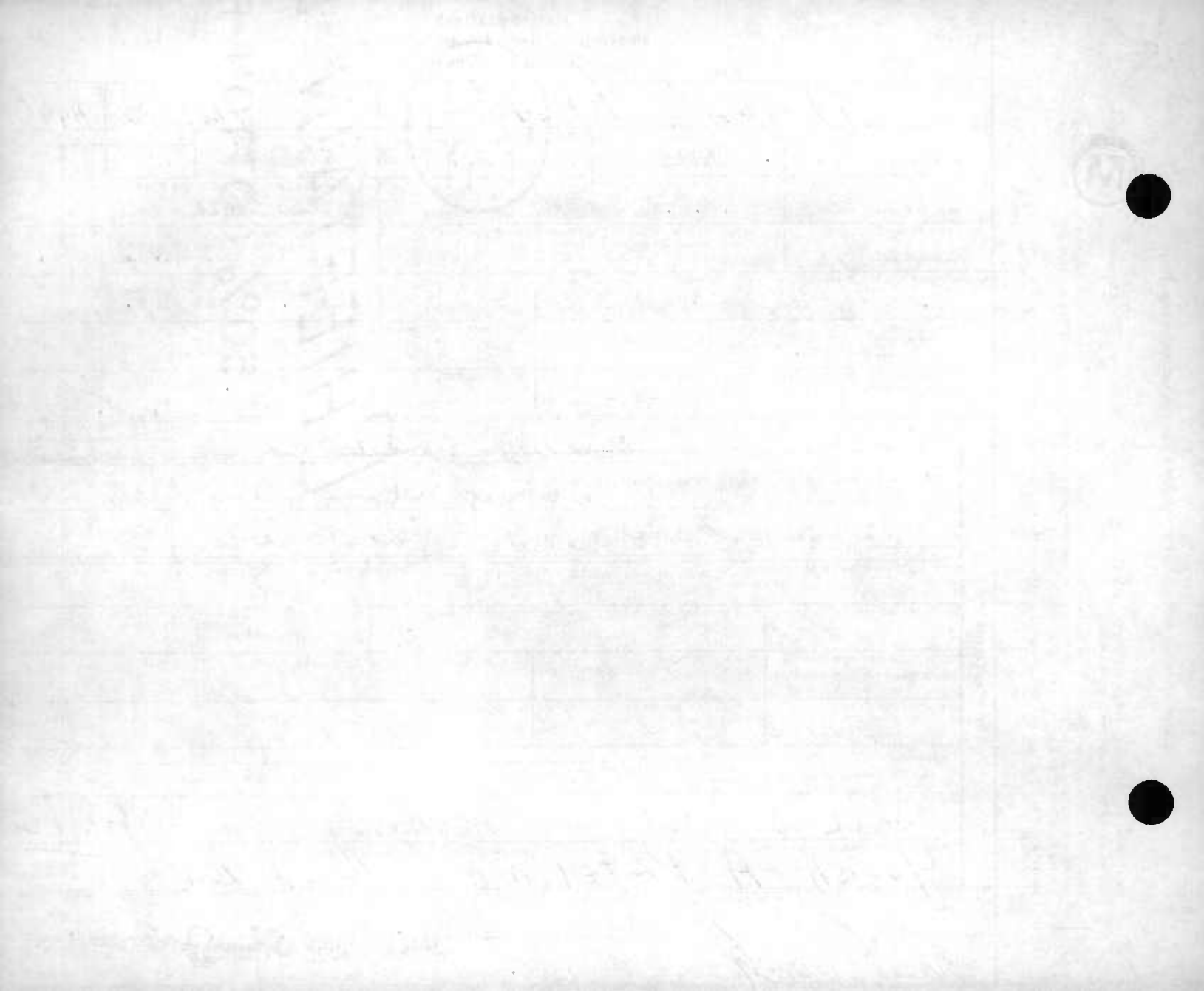
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1 - FOR
STATE
REGISTRAR

REG. NO.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Thelma Khudy</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>1/25/82</i> | | 2b. HOUR <i>449 P.M.</i> |
| 3. SEX <i>Female</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>April 14, 1907</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> MD. | | |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bookkeeper</i> | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i> | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE <i>MD.</i> | 13b. COUNTY <i>Cecil</i> | 13c. CITY OR TOWN <i>North East</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>205 E. Cecil Ave.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Cicero L. Wood</i> | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ivy Thomas</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>212-01-5276A</i> | 17. INFORMANT ADDRESS <i>170 N. George St North East, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4149</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Melanotic Breast Cancer</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Yogish A. Patel</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1/26/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Yogish A. Patel, M.D.</i> | | 22e. ADDRESS <i>Newark, Del.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>1-30-82</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>North East Meth.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>North East Cecil Md.</i> |
| 24. FUNERAL DIRECTOR <i>North East, Md.</i> | | | | | |

JAN 26 1982



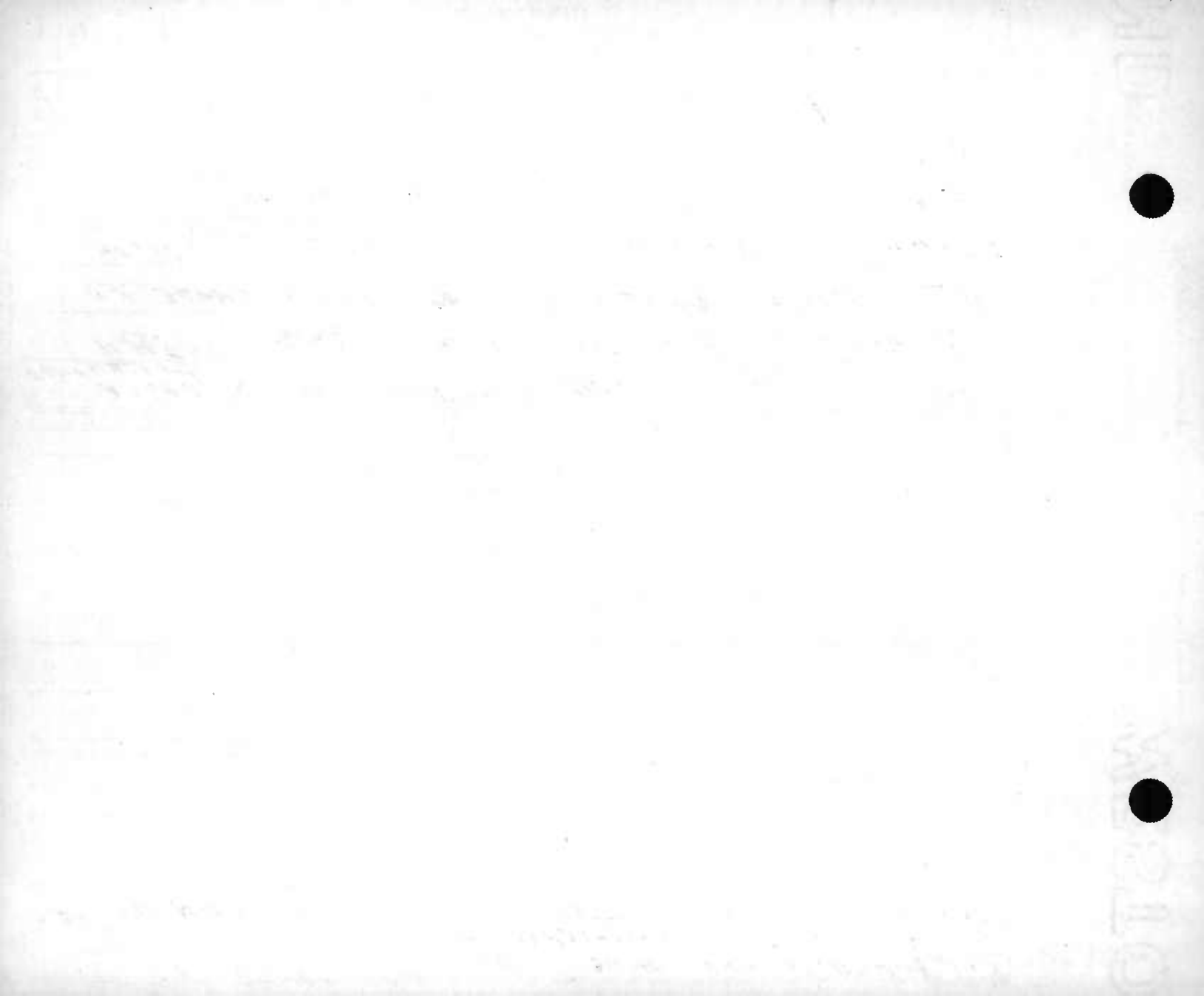
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 7 1 | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. FOR STATE REGISTRAR <u>PERCY</u> | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>PERCY</u> <u>W</u> <u>ROBINSON</u> | | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>17</u> YEAR <u>82</u> | | 2b. HOUR <u>4:55 P.M.</u> | |
| 3. SEX <u>M</u> | | 4. RACE <u>W</u> | | 5. DATE OF BIRTH MONTH <u>10</u> DAY <u>21</u> YEAR <u>07</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>PA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cecil</u> | |
| 10. CITY OR TOWN OF DEATH <u>ELKTON</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>U. H. H. H.</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>RET.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> 13b. COUNTY <u>Cecil</u> 13c. CITY OR TOWN <u>ELKTON</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <u>124 S. SHORE RD</u> | | | |
| 14. FATHER'S NAME FIRST <u>ROBERT</u> MIDDLE <u>ROBINSON</u> LAST <u>ELIZIA</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>JANE</u> MIDDLE <u>LOGAN</u> LAST <u>ELKTON</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>159-01-1669</u> | | 17. INFORMANT ADDRESS <u>MARGARET M. COSGROVE</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUDDEN CARDIAC DEATH</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ISCHEMIC HEART DISEASE</u> (c) <u>CONDUCTIVE PATHOLOGICAL CHANGES</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>HEART FAILURE</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <u>ABOUT 1960</u> 19 <u>1-17-82</u> 19 <u>1-17-82</u> , that (I) (we) last saw the deceased alive on <u>ABOUT 1 MONTH AGO</u> 19 <u>1-17-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (we) view the body after death. <u>DO NOT VIEW THE BODY AFTER DEATH</u> | | | | | | | |
| 22b. SIGNATURE <u>P. M. H. H.</u> | | | | 22c. DATE SIGNED <u>1-17-82</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PHILIP POLLACK, M.D.</u> | |
| 22e. ADDRESS <u>131 W. MAIN ST ELKTON MD 21921</u> | | | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u> | | 23b. DATE <u>1-18-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SILVERBROOK</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>WILMINGTON N.C. TEX</u> | |
| 24. FUNERAL DIRECTOR NAME <u>R. T. FORD FUNERAL HOME</u> ADDRESS <u>MD</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 6 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| FOR 1. STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST <i>Willis C. Shallcross</i> | | MONTH DAY YEAR <i>1/6/82</i> HOUR <i>355</i> ^M | |
| 1. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| <i>Male</i> | <i>White</i> | MONTH DAY YEAR <i>9 22 1926</i> | <i>55</i> YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| <i>Maryland</i> | <i>USA</i> | | <i>Cecil</i> MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| <i>Elkton</i> | <i>Union Hospital, Elkton, Maryland</i> | <i>Construction</i> | <i>Building</i> |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN |
| <i>Maryland</i> | <i>Cecil</i> | <i>Elkton</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | 13e. STREET ADDRESS | |
| <i>Howard</i> | <i>Shallcross</i> | <i>30 Oak Tree Lane</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT ADDRESS | |
| <i>Yes</i> | <i>WW-II</i> | <i>Mildred Shallcross, 30 Oak Tree Lane, Elkton, Maryland 21921</i> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Failure</i> <i>1541</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Rectum</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-2 months</i> <i>Several months</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| <i>11-30-81</i> | <i>Abdominal-Perineal resection of Colon & Rectum</i> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from <i>November 5</i> 19 <i>81</i> , to <i>1-6</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>1-5</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE <i>Donald C. Edgren M.D.</i> | |
| 22c. DATE SIGNED <i>1-8-82</i> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD C. EDGREN M.D.</i> | |
| 22e. ADDRESS <i>721 BRIDGE ST. ELKTON, MARYLAND</i> | | 22f. DATE SIGNED <i>1-8-82</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| <i>Burial</i> | <i>1/11/82</i> | <i>Harford Memorial Gdn's</i> | <i>Aberdeen, R.D., Harford Md.</i> |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25. REGISTRAR'S SIGNATURE | |
| <i>Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399</i> | | <i>JAN 1 1982 REGISTRAR</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 7 3 | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN P. SHOCKLEY | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 12, 1982 | | 2b. HOUR 1:50am | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 2 29 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DEL | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD. | |
| 10. CITY OR TOWN OF DEATH Perry Point | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY GRAIN | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | | 13b. COUNTY CECIL | | 13c. CITY OR TOWN CHESAPEAKE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN S HECKEL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE N/A | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. 212-38-1411 | | 17. INFORMANT ADDRESS MARIE ELWOOD CHESAPEAKE CITY MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest | | | | | | | |
| 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of prostate gland | | | | | | | |
| (c) Renal failure w/uremia and anemia | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertensive cardio-vascular disease (b) Chronic obstructive pulmonary disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that xx (this hospital) attended the deceased from November 23, 81 to January 12, 82 xxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT) J. R. GARCIA, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1-12-82 | |
| 22e. ADDRESS VA Medical Center, Perry Point, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY BETHEA | | 23d. LOCATION CITY OR TOWN COUNTY STATE CHESAPEAKE CITY CECIL MD | |
| 24. FUNERAL DIRECTOR'S NAME Foard Funeral Home, Chesapeake City, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1982 | | 25b. REGISTRAR'S SIGNATURE Anna J. Garcia | |

BP

Food Trencher House, Chesapeake City, Md.

J. E. CARPIS, M.D.

VA Medical Center, Tarry Town, Md.

1-10-69

x

62 xxxxxx

January 12

November 12 61

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Hypertensive cardiac-vascular disease

Chronic obstructive pulmonary disease

Form: Ischemic Vascular and aneurysm

Control of vascular system

Cerebro-vascular disease

212-32-111

VA Medical Center

Tarry Town

1969

7

SHOULDER

January 12, 1969

1:50pm

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|-----------------------------------|-----------------|---|------------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8 2 0 1 7 7 4 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| WILLIAM A. SLERT Jr. | | | January 11, 1982 | | | | | | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | White | | Sept 1, 1919 | | 62 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | | | Cecil County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Perry Point | | | VA Medical Center | | | Stevadore | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET ADDRESS | | | | |
| Md. A.A. Co. Brooklyn | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 703 Matthew Ave. | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| William A. Slert Sr. | | | Louisa Reese | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| Yes | | | W.W. II 219-01-7167 | | | Mrs. Marie Vykol same as 13 e | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Adenocarcinoma of lungs w/metastasis | | | | | | | | | | | | | |
| 1629 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | STREET | | | CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 14, 1981, to January 11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| Roy W. Chesnut, M.D. | | | MD. | | | | | | 1-12-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| ROY W. CHESNUT, M.D. | | | VAMC, Perry Point, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | | |
| Burial | | | 1/15/82 | | | Cedar Hill Cemetery | | | Brooklyn A.A. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| George Gonce Funeral Home, Baltimore, Md. | | | 4001 Ritchie Hwy | | | JAN 12 1982 | | | | | | | |

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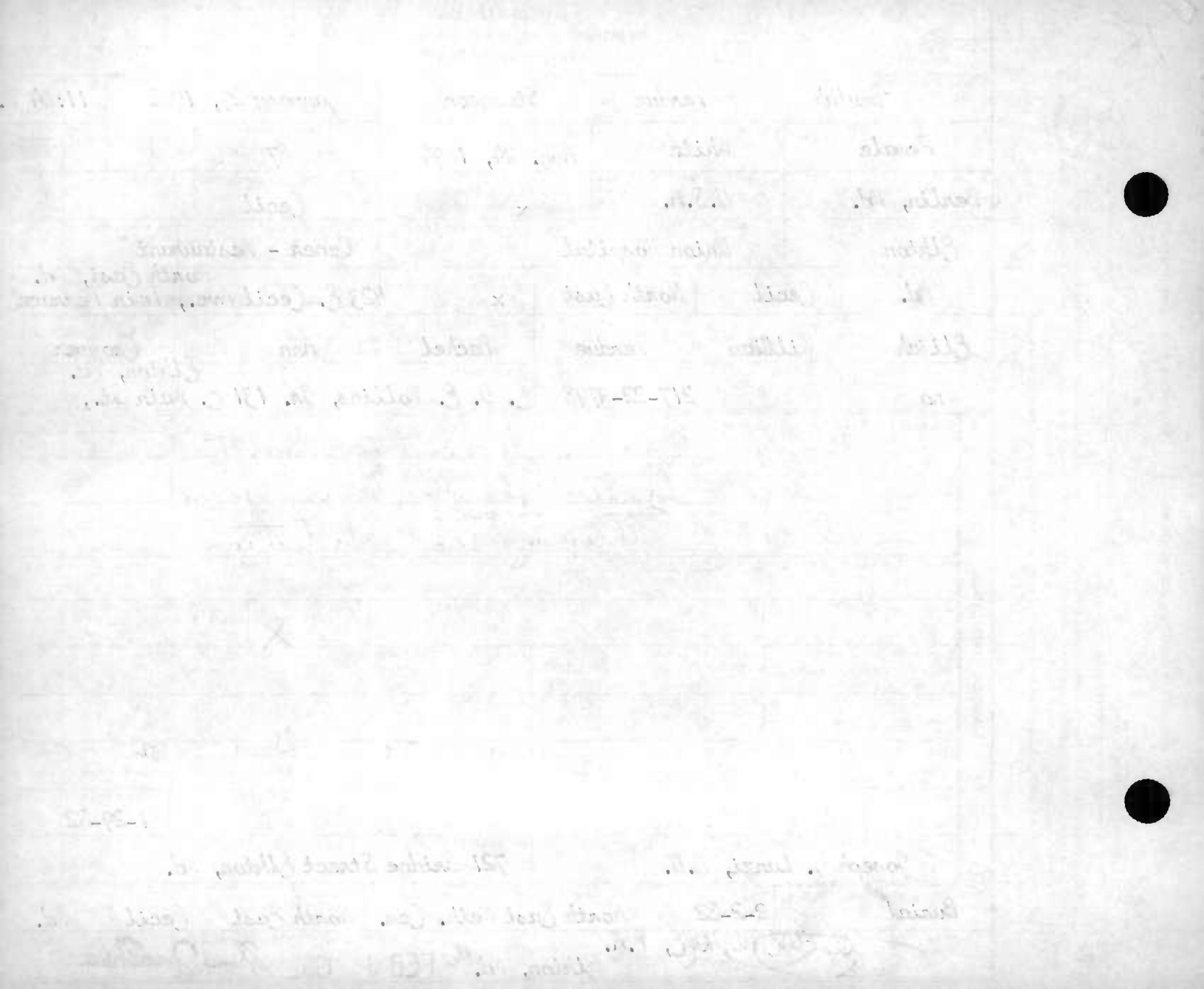
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | | | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|--|------------------------------------------|--|------------------|--|------------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Beulah</i> | | | | | | MIDDLE <i>Perdue</i> | | | | | | LAST <i>Sturgeon</i> | | | | | | January 29, 1982 | | 11:04 P.M. | | | |
| 3. SEX <i>Female</i> | | | | 4. RACE <i>White</i> | | | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | | | IF UNDER 24 HRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) <i>Bertin, Md.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i> | | | | MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Elkton</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner - Restaurant</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE <i>Md.</i> | | | | | | 13b. COUNTY <i>Cecil</i> | | 13c. CITY OR TOWN <i>North East</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>North East, Md. 423 E. Cecil Ave., Twin Terrace</i> | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| FIRST <i>Elijah</i> MIDDLE <i>William</i> LAST <i>Perdue</i> | | | | | | FIRST <i>Rachel</i> MIDDLE <i>Ann</i> LAST <i>Cropper</i> | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | | | | 16b. SOCIAL SECURITY NO. <i>217-22-3798</i> | | | | | | 17. INFORMANT ADDRESS <i>E. D. E. Rollins, Jr. 131 E. Main St., Elkton, Md.</i> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 5990 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Sclerotic Heart Disease</i> | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Urinary Tract Infection</i> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>May</i> 19 <i>79</i> to <i>JAN</i> 19 <i>82</i> , that (1) <input checked="" type="checkbox"/> we last saw the deceased alive on <i>JAN</i> 19 <i>82</i> , and that (1) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (2) <input type="checkbox"/> we did not view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph G. Lanzi</i> DEGREE | | | | | | | | | | | | | | 22c. DATE SIGNED <i>1-29-82</i> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzi, M.D.</i> | | | | | | | | | | | | | | 22e. ADDRESS <i>721 Bridge Street Elkton, Md.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | | | 23b. DATE <i>2-2-82</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>North East Meth. Cem.</i> | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>North East Cecil Md.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>SEE FUNERAL HOME, P.A.</i> ADDRESS <i>Elkton, Md.</i> | | | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1982</i> | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | REG. NO. 8201176 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William P. Taylor | | | | | | 2a. DATE OF DEATH MONTH 1/19/82 DAY 22 HOUR 27 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH August DAY 19 YEAR 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Thiokol Corp. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Elkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS 40 Majors Lane | | | | | | | |
| 14. FATHER'S NAME FIRST William MIDDLE - LAST Taylor | | | | 15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE - LAST Zahn | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. Korean | | 17. INFORMANT ADDRESS 213-26-0278 Mrs. Dorothy E. Taylor, Elkton, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Hepatic Failure | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| (b) Advanced Stomach Cancer | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1519 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/11/82 19 82 , to 1/19/82 19 82 , that (I) (we) last saw the deceased alive on 1/19/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Yogish A. Patel DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogish A. Patel | | | | 22e. ADDRESS NEWARK Del | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Donald S. Hicks ADDRESS HICKS HOME for FUNERALS, ELKTON, MD. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1982 | | 25b. REGISTRAR'S SIGNATURE Frances J. Mathews | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 0 1 7 7 7 | | | | | | | | | |
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| 1. DECEASED NAME (TYPE OR PRINT) Solomon William Wagner | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/26 19 82 | | 2b. HOUR 8P M | | | | | | | |
| 3. SEX M | | 4. RACE C | | 5. DATE OF BIRTH 7/26/12 MONTH DAY YEAR | | 6. AGE (IN YEARS) 69 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 1/26 19 82 | | 2d. HOUR 9P M | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun, MD | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home - 9 Rolling Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm hand | | | | 12b. KIND OF BUSINESS OR INDUSTRY Farm | | | | | | | |
| 13a. STATE MD | | | | 13b. COUNTY Cecil | | | | 13c. CITY OR TOWN Rising Sun MD | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS 21911 9 Rolling Dr., Rising Sun, MD | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harrison William Wagner | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Keene | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 195-26-4450 | | | | 17. INFORMANT 2 Shutt Dr. Newark, De. Virginia M Kreps (daughter) | | | | 17. ADDRESS 19711 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). heavy smoker >50 years | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) found dead in bed. | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Henry Farkas | | | | TITLE (SPECIFY) Deputy M.D. | | | | MEDICAL EXAMINER | | | | DATE SIGNED 1/27/82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Henry Farkas MD | | | | ADDRESS Union Hospital of Cecil County, MD | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/30/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Ridge Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE McClure, Mifflin Co., Penna. | | | | | | | |
| 24. FUNERAL DIRECTOR John C Hinge | | | | 24. ADDRESS 404 E Market Sts. Wilmington, DE | | | | 25a. DATE JAN 29 1982 | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |

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DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

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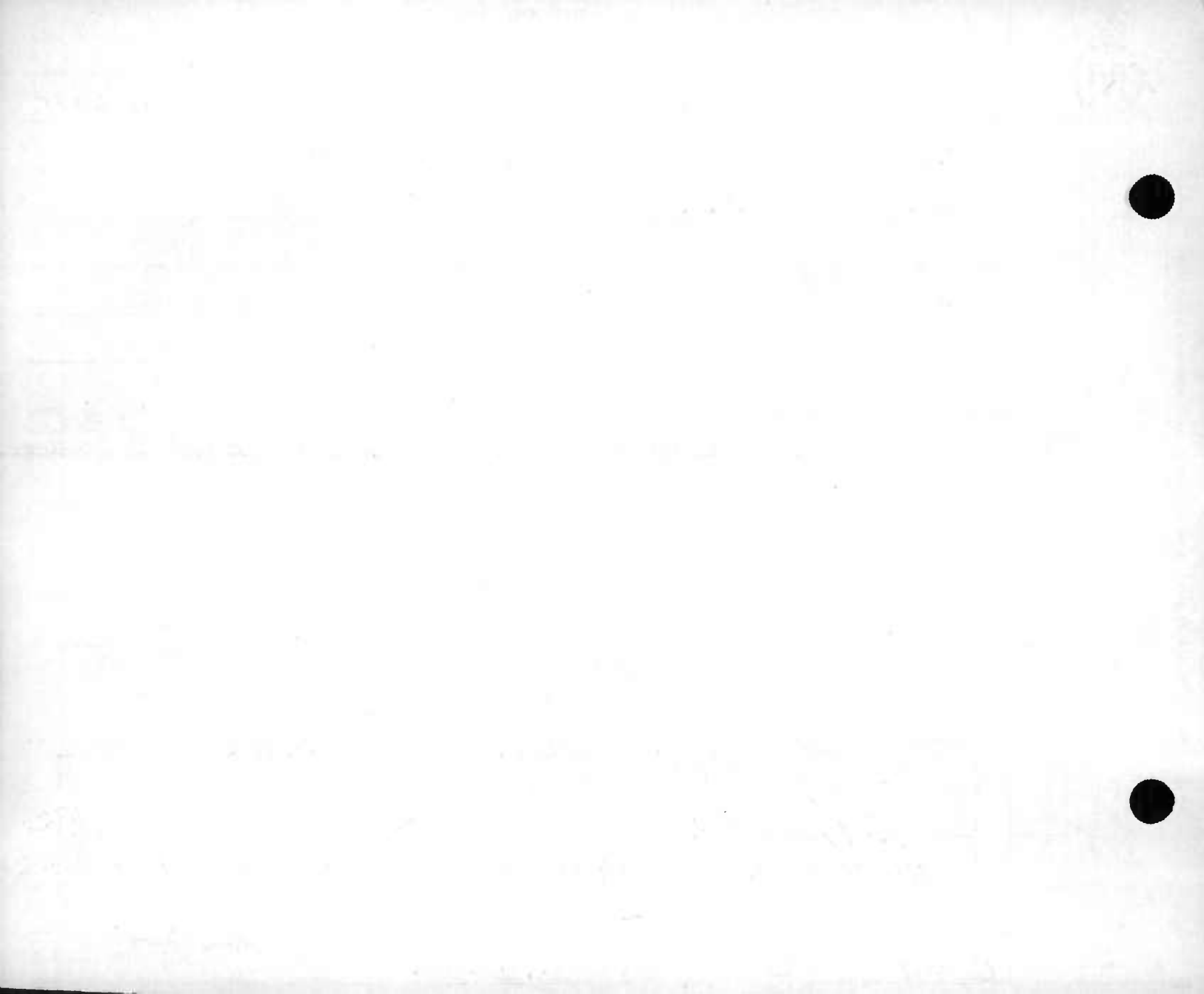
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 0 1 7 7 8 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM G WEBSTER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 2 / 82 6 05 P.M. | | | |
| 3. SEX M | | 4. RACE C Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 10 17 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 67 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD. | |
| 10. CITY OR TOWN OF DEATH Elkton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Chesapeake | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anos Webster | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Webster | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | |
| 16b. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT 222 Charles St., Lucy Gibbs- Chesapeake City, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BILATERAL PNEUMONIA WITH PLEURAL EFFUSIONS.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CHRONIC ETHANOLISM</u> | | | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12/25/81</u> 19____, to <u>1/2/82</u> 19____, that (I) (we) lost saw the deceased alive on <u>1/2/82</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANANT B. SINGH, M.D. | | 22e. ADDRESS UNKNOWN 17501TH, ELKTON MD 21921 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Bohemia Manor | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bohemia Manor Md. | |
| 24. FUNERAL DIRECTOR NAME Edgar Bell | | ADDRESS 909 Poplar St., Wil. Del. | | 25a. DATE RECD. BY REGISTRAR JAN 14 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| REG. NO. 8 2 0 1 7 7 9 | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stanley Archibald Welsh | | | | | MONTH DAY YEAR Jan. 23, 82 | | | 2b. HOUR 9:10P | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4-- 10-- 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD. | | | |
| 10. CITY OR TOWN OF DEATH Rising Sun, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor N. H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supt. Boat Mfg. | | 12b. KIND OF BUSINESS OR INDUSTRY Ret. | |
| 13a. STATE Md. | | | | | 13b. COUNTY Cecil | | 13c. CITY OR TOWN Rising Sun | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Welsh | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Green | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 184-07-4824 | | 17. INFORMANT Mrs. Rodney Buntly | | ADDRESS A.350 Rising Sun Rd. Rising Sun, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alzheimer's Disease</u> <u>3310</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>6 yrs.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> 19 <u>75</u> , to <u>1-29</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Neil R Taylor MD.</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-25-82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor | | | | 22e. ADDRESS Rising Sun, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 26, 82 | | 23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Colora Cecil Md. | | | |
| 24. SIGNATURE OF DIRECTOR <u>James Van Vleet</u> | | | | ADDRESS Rising Sun, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1982 | | 25b. REGISTRAR'S SIGNATURE <u>James Van Vleet</u> | |

BP

